

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Order of United Commercial Travelers of America</i>	<i>State Tracking Number:</i>	<i>41083</i>
<i>Company Tracking Number:</i>	<i>AMH9AROC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>UCT 2009 MS OC</i>		
<i>Project Name/Number:</i>	<i>UCT/AMH9AROC</i>		

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: UCT 2009 MS OC

SERFF Tr Num: WAKE-125943797 State: ArkansasLH

TOI: MS06 Medicare Supplement - Other

SERFF Status: Closed

State Tr Num: 41083

Sub-TOI: MS06.000 Medicare Supplement - Other

Co Tr Num: AMH9AROC

State Status: Under Review

Filing Type: Form

Co Status:

Reviewer(s): Stephanie Fowler

Author: Toni Hess

Disposition Date: 01/08/2009

Date Submitted: 12/12/2008

Disposition Status: Filed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: UCT

Status of Filing in Domicile: Not Filed

Project Number: AMH9AROC

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/08/2009

State Status Changed: 01/08/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: The Order of United Commercial Travelers of America

NAIC Number: 56383

FEIN Number: 31-4273120

SUBMISSION

Medicare Supplement – Outline of Coverage – Form Number: MSI OC 09 AR

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
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Wakely Actuarial Services, Inc. has been retained by The Order of United Commercial Travelers of America to file the above-captioned form on their behalf. We are requesting the review and approval of these forms. A letter of authorization is included for reference.

All required filing documents have been completed and are included with the filing.

The filing of this Medicare Supplement Outline of Coverage represents the annual filing of this outline as required by your state. This outline will be used with the Medicare Supplement Plans A, B, E, and F approved on 9/2/05 and Plan G approved on 6/6/06 and reflect the 2009 Medicare Deductibles/Coinsurance amounts and the applicable rates.

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAS01)

Toni Hess, Compliance Consultant	toni.hess@hesscc.com
4119 Font Hill Court	(215) 757-0508 [Phone]
Langhorne, PA 19047	

Filing Company Information

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Drive, Suite 100	Group Code: -99	Company Type:
P.O. Box 159019		
COLUMBUS, OH 43215-8619	Group Name:	State ID Number:
(800) 848-0123 ext. [Phone]	FEIN Number: 31-4273120	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No

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<i>Product Name:</i>	<i>UCT 2009 MS OC</i>		
<i>Project Name/Number:</i>	<i>UCT/AMH9AROC</i>		
Fee Explanation:	\$20 for form filing		
Per Company:	No		

State: *Arkansas*

Filing Company: *The Order of United Commercial Travelers of America* State Tracking Number: 41083

Company Tracking Number: AMH9AROC

TOI: *MS06 Medicare Supplement - Other*

Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: UCT 2009 MS OC

Project Name/Number: UCT/AMH9AROC

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	\$20.00	12/12/2008	24498287

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Project Name/Number:</i>	<i>UCT/AMH9AROC</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	01/08/2009	01/08/2009

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
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Disposition

Disposition Date: 01/08/2009

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-125943797 State: Arkansas

Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 41083

Company Tracking Number: AMH9AROC

TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: UCT 2009 MS OC

Project Name/Number: UCT/AMH9AROC

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Authorization Letter	Accepted for Informational Purposes	Yes
Form	Medicare Supplement Outline of Coverage	Filed	Yes

SERFF Tracking Number: WAKE-125943797 State: Arkansas

Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 41083

Company Tracking Number: AMH9AROC

TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: UCT 2009 MS OC

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Form Schedule

Lead Form Number: MSI OC 09 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	MSI OC 09 AR	Outline of Coverage	Medicare Supplement Outline of Coverage	Initial		47	MSI OC 09 AR.pdf

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, E, F and G

These charts show the benefits included in each Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$1,860 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include, in Plan J, the plan’s separate prescription drug deductible or, in Plans F and J, the plan’s separate foreign emergency deductible.

Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit ***	\$2220 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**

Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exceptions.

FOR USE IN ALL ARKANSAS ZIP CODES All Ages/All Genders/Smoker/Non Smoker

Annual Premium Rates

Plan A 1,725.28

Plan B 2,640.76

Semi Annual Premium Rates

Plan A 888.50

Plan B 1,359.98

Quarterly Premium Rates

Plan A 452.86

Plan B 693.18

Monthly Premium Rates (EFT)

Plan A 143.75

Plan B 220.05

Monthly Premium Rates (Direct)

Plan A 172.52

Plan B 264.07



THE ORDER OF
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Home Office:
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1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, OH 43215
(614) 487-9680 • Toll-free: (800) 848-0123 • Fax: (614) 487-9675
Visit our web site at www.uct.org

**FOR USE IN ARKANSAS ZIP CODES
ZIP CODE - 722**

All Ages/All Genders

Non Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	1827.06	940.92	479.60	152.23	182.70
Plan F	2111.68	1087.51	554.31	175.96	211.16
Plan G	1868.75	962.40	490.53	155.71	186.87

Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	2284.18	1176.35	599.58	190.33	228.41
Plan F	2640.68	1359.95	693.17	220.03	264.06
Plan G	2333.06	1201.52	612.42	194.41	233.30



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**FOR USE IN ARKANSAS ZIP CODES
ZIP CODE – 720-721**

All Ages/All Genders

Non Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	1644.35	846.83	431.63	137.01	164.42
Plan F	1900.51	978.76	498.87	158.36	190.05
Plan G	1681.88	866.16	441.48	140.15	168.18

Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	2055.76	1058.71	539.63	171.30	205.57
Plan F	2376.61	1223.95	623.85	198.03	237.65
Plan G	2099.75	1081.36	551.17	174.96	209.97



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FOR USE IN ARKANSAS ZIP CODES

ZIP CODES – 716-719, 723-729

All Ages/All Genders

Non Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	1553.00	799.78	407.66	129.40	155.30
Plan F	1794.92	924.38	471.16	149.56	179.48
Plan G	1588.44	818.03	416.96	132.36	158.83

Smoker

	Annual	Semi Annual	Quarterly	Monthly (EFT)	Monthly Direct
Plan E	1941.55	999.90	509.65	161.78	194.15
Plan F	2244.57	1155.95	589.20	187.03	224.45
Plan G	1983.10	1021.28	520.56	165.25	198.30

PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your issue age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: The Order of United Commercial Travelers of America, 632 North Park Street, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do ***NOT*** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither The Order of United Commercial Travelers of America nor its agents are connected with Medicare.

This outline of coverage does not give all of the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$0 \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$1068 (Part A Deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$131 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$131 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$131 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES –TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$131 (Part B Deductible) \$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$131 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$131 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$131 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES –TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$131 (Part B Deductible) \$0

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$131 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$131 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$131 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$131 (Part B Deductible) \$0

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum
*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventative tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	\$0 \$0	\$120 \$0	\$0 All costs

*** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.**

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$131 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$131 (Part B Deductible) Generally 20%	 \$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$131 (Part B Deductible) 20%	 \$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$131 (Part B Deductible) 20%	 \$0 \$0 \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000.	 \$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$131 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$131 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$131 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) - Calendar year maximum	100% \$0 80% \$0 \$0 \$0	\$0 \$0 20% Actual charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week. \$1,600	\$0 \$131 (Part B Deductible) \$0 Balance
OTHER BENEFITS – NOT COVERED BY MEDICARE			
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Order of United Commercial Travelers of America</i>	<i>State Tracking Number:</i>	<i>41083</i>
<i>Company Tracking Number:</i>	<i>AMH9AROC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>UCT 2009 MS OC</i>		
<i>Project Name/Number:</i>	<i>UCT/AMH9AROC</i>		

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>WAKE-125943797</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Order of United Commercial Travelers of America</i>	<i>State Tracking Number:</i>	<i>41083</i>
<i>Company Tracking Number:</i>	<i>AMH9AROC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>UCT 2009 MS OC</i>		
<i>Project Name/Number:</i>	<i>UCT/AMH9AROC</i>		

Supporting Document Schedules

	Review Status:	
Satisfied -Name: Certification/Notice		12/11/2008
Comments:		
Attachments:		
Regulation 19 AR OC.PDF		
Regulation 49 AR OC.PDF		
AR - Readability.pdf		
CONS NOT.pdf		
	Review Status:	
Bypassed -Name: Application		12/11/2008
Bypass Reason: Not Applicable to this filing.		
Comments:		
	Review Status:	
Bypassed -Name: Health - Actuarial Justification		12/11/2008
Bypass Reason: Not Applicable to this filing.		
Comments:		
	Review Status:	
Bypassed -Name: Outline of Coverage		12/11/2008
Bypass Reason: This is a filing for the Outline of Coverage and the form is attached under the Form Tab.		
Comments:		
	Review Status:	
Satisfied -Name: Authorization Letter	Accepted for Informational Purposes	01/08/2009
Comments:		
Attachment:		
UCT Authorization.pdf		

ARKANSAS
Rule and Regulation 19 Certification

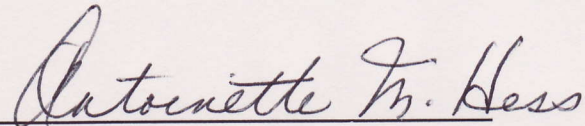
Title of Form(s)

Form Number

Outline of Coverage

MSI OC 09 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.



Signature

Antoinette M. Hess

Name

Compliance Consultant

Title

ARKANSAS
Rule and Regulation 49 Certification

Title of Form(s)

Form Number

Outline of Coverage

MSI OC 09 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.



Signature

Antoinette M. Hess

Name

Compliance Consultant

Title

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

**The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
Columbus, Ohio 43215**

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Outline of Coverage	MSI OC 09 AR	46.9

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.



Signature

Ronald E. Hunt

Name

Executive Vice-President

Title

Consumer Notice
The Order of United Commercial Travelers of America

Policyholder Service Office: 1801 Watermark Drive, Suite 100
Columbus, Ohio 43215-8619
Telephone Number: 800-848-0123

Name of Agent: [Fred Smith]
Agent Address: [123 First Street, Any Town, Arkansas]
Agent Telephone Number: [555-555-1234]

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460



THE ORDER OF
UNITED COMMERCIAL TRAVELERS OF AMERICA

632 NORTH PARK STREET, P.O. BOX 159019 COLUMBUS, OHIO 43215-8619
(614) 228-3276 • TOLL-FREE: (800) 848-0123 • FAX: (614) 228-1898 • www.uct.org

November 25, 2008

J. Steven Keck, FSA, MAAA
Wakely Actuarial
34125 US Highway 19 North, Suite 310
Palm Harbor, FL 34684

Dear Mr. Keck:

Wakely Actuarial is hereby authorized to perform filings on behalf of The Order of United Commercial Travelers of America.

Thank you.

Sincerely,

Kevin C. Hecker
Vice President and Controller